**CABINET FOR HEALTH SERVICES**
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

**DEPARTMENT FOR MEDICAID SERVICES**
"An Equal Opportunity Employer M/F/D"

September 29, 2003

Nursing Facility Provider Letter # A-193

Dear Nursing Facility Provider:

This letter is to notify you that effective November 1, 2003, National Health Services, formerly Healthcare Review, will no longer conduct telephonic Level of Care (LOC) determination reviews. All requests must be submitted using the Revised PRO Fax form (MAP-726A dated 9/2003). You may begin using this form upon receiving this letter.

These changes are being made due to newly enhanced programs by National Health Services. Your faxed information will go directly into their server that will place the information into their data base and help to expedite the Level of Care detemination process.

The Department recommends that you maintain documentation of the Fax transmittal indicating a successful transmission. Employee notes are not acceptable documentation of Fax transmissions. Please include a cover sheet containing the following information: facility name, number of pages submitted,and facility contact name and telephone number.

Please use these fax numbers when submitting information: (502) 429-5233, (800) 807-7840 or (800) 807-8843.

If you have any questions, please contact Sherilyn Redmon, Branch Manager, Facilities Services Branch at (502) 564-5707.

Sincerely,

Mike Robinson
Commissioner

MR/vb

Enclosure

MAP-726A
Revised 9/2003

# NURSING FACILITY LEVEL OF CARE
# REQUEST FOR ADMISSION

Resident Name _____ Medicaid # _____-_____-_____

Room # _____ Room Certified for Medicaid ☐ Yes ☐ No

If Pending Medicaid, Social Security # _____-_____-_____

Medicare # _____ Date of Birth _____/_____/_____

Marital Status ☐ M ☐ W ☐ S ☐ D ☐ Male ☐ Female

Responsible Party _____

Responsible Party Address _____

Relationship _____

Diagnoses _____

_____

_____

Living Arrangements Prior To Admission _____

_____

**CHECK ONE ONLY:**

☐ New Admit Date _____/_____/_____

☐ Readmit Date _____/_____/_____

☐ Pay Source Change Date _____/_____/_____

(Last Admit Date _____/_____/_____)

| Admission or Readmission From: | |
|---|---|
| Acute Care Hospital | |
| Free-Standing Psychiatric Hospital | |
| Home | |
| ICF/MR/DD | |
| Nursing Facility | |
| Personal Care Home | |
| Other: | |

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# NURSING FACILITY LEVEL OF CARE
# REQUEST FOR ADMISSION

***PASRR LEVEL I FORM (AND IF APPLICABLE, THE LEVEL II FORM) MUST BE COMPLETED AND A COPY FAXED WITH ALL NEW ADMISSIONS AND ALL PAY SOURCE CHANGES.**

Level I PASRR Date _____/_____/_____ Completed By _____

Level II PASRR Date _____/_____/_____ Appropriate for NF Placement? ☐ Yes ☐ No

Completed By _____

Verbal Determination Form
(Mental Illness Only) Date _____/_____/_____ Appropriate for NF Placement? ☐ Yes ☐ No

Completed By _____

Inappropriate Referral Date _____/_____/_____ Completed By _____

| NF Name | Facility ID #<br>Phone ( ) |
|---|---|
| Physician Name<br>Address | Physician Phone<br>( )<br><br>Fax # ( ) |
| Physician License # | |
| **MEDICATIONS** | |
| Describe resident's medications: Number of Oral, Tube, Topical, Inhalers, Sprays, or Patches. List the name and frequency of any IV, SQ, or IM medications (include routine flushes), Routine Administration of Oxygen (i.e., new administration of oxygen or regulating oxygen, how often checking pulse oximetry, etc.) and Nebulizer Treatments. | |
| | |
| | |
| | |
| | |
| | |
| | |

Is resident capable of self-administering medications? ☐ Yes ☐ No If no, why_____

_____

# NURSING FACILITY LEVEL OF CARE
# REQUEST FOR ADMISSION

## COGNITIVE ABILITIES

| | | |
|---|---|---|
| Comatose | Y N | If Yes, Proceed to Communication |
| Memory Recall: | | |
| Knows Own Name | Y N | Comments: |
| Knows Date/Time | Y N | Comments: |
| Knows Location | Y N | Comments: |
| Knows Staff | Y N | Comments: |

## COMMUNICATION /HEARING ABILITIES

| | | | | |
|---|---|---|---|---|
| Hears Adequately | Y N | Uses Speech to Communicate | Y N | Comments: |
| Hearing Aid Use | Y N | Understands Verbal Direction | Y N | Comments: |

## VISION PATTERNS

| | | |
|---|---|---|
| Vision Adequate | Y N | Comments: |
| Visual Limitations | Y N | Comments: |

## MOOD AND BEHAVIOR

| | | |
|---|---|---|
| Wanders | Y N | Comments: |
| Physically Abusive | Y N | Comments: |
| Verbally Abusive | Y N | Comments: |
| Socially Inappropriate | Y N | Comments: |
| Resists Care | Y N | Comments: |

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# NURSING FACILITY LEVEL OF CARE
# REQUEST FOR ADMISSION

## ACTIVITIES OF DAILY LIVING

**Bed Mobility :**
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
How often requires assist? _____
Bedbound ☐ Yes ☐ No

**Transfer :**
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
To/From ☐ Bed ☐ Chair ☐ Wheelchair
How often requires assist? _____

**Ambulation :**
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
How often requires assist? _____
Standby assist ☐ Yes ☐ No
How often requires assist? _____
Independent with device ☐ Yes ☐ No
Wheelchair per self ☐ Yes ☐ No
Wheelchair assist ☐ Yes ☐ No
How often requires assist? _____

**Bathing :**
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
How often requires assist? _____
Standby assist ☐ Yes ☐ No
How often requires assist? _____
☐ Back ☐ Arms
☐ Legs ☐ Hands
☐ Feet

**Dressing :**
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
☐ Pulling on pants ☐ Putting on shirt
☐ Buttons, Zippers ☐ Prothesis
How often requires assist? _____
☐ Continuous Supervision/Cues

**Grooming :**
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
☐ Hair ☐ Nails
☐ Teeth ☐ Shaving
☐ Makeup
How often requires assist? _____
☐ Continuous Supervision/Cues

**Toileting :**
Independent ☐ Yes ☐ No
Hands on assist ☐ Yes ☐ No
☐ Pericare ☐ Adjust Clothing ☐ On/Off Toilet
☐ Changing pads/briefs ☐ Manage ostomy/catheter
How often requires assist? _____
☐ Continuous Supervision/Cues

| ADL Comments |
|---|
| |
| |
| |
| |
| |

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# NURSING FACILITY LEVEL OF CARE
# REQUEST FOR ADMISSION

## NUTRITIONAL STATUS

| | |
|---|---|
| Type of Diet | ☐ Regular ☐ Low Sodium ☐ Healthy Heart ☐ Other |
| Height | Weight |
| Feeding | ☐ Independent with Tray Set Up<br>☐ Receives Partial Hands on Assist to Eat<br>☐ Total Feed<br>☐ Continuous Verbal Cues |
| Tube Feeding Required | ☐ Yes ☐ No<br>If Yes, Explain Amount _____<br>Brand _____<br>Frequency _____<br>H20 Flushes & Frequency _____ |

## SKIN CONDITIONS

| Number of Decubitus Ulcers | Stage 1 | Stage 2 | Stage 3 | Stage 4 |
|---|---|---|---|---|
| Type of Ulcer | Pressure/Stasis | Pressure/Stasis | Pressure/Stasis | Pressure/Stasis |
| Treatment | | | | |
| Other Skins Problems | | | | |
| Treatment | | | | |

# NURSING FACILITY LEVEL OF CARE
# REQUEST FOR ADMISSION

## THERAPIES

| | | | |
|---|---|---|---|
| Physical Therapy | Y N | Days Per Week: | Comments: |
| Occupational Therapy | Y N | Days Per Week: | Comments: |
| Speech Therapy | Y N | Days Per Week: | Comments: |
| Respiratory Therapy | Y N | Days Per Week: | Comments: |

## NURSING REHABILITATION/RESTORATIVE CARE

| | | | |
|---|---|---|---|
| a. Range of Motion (Passive) | Y N | Days Per Week: | Comments: |
| b. Range of Motion (Active) | Y N | Days Per Week: | Comments: |
| c. Splint or Brace Assistance | Y N | Days Per Week: | Comments: |
| d. Bed Mobility | Y N | Days Per Week: | Comments: |
| e. Transfer | Y N | Days Per Week: | Comments: |
| f. Walking | Y N | Days Per Week: | Comments: |
| g. Dressing or Grooming | Y N | Days Per Week: | Comments: |
| h. Eating or Swallowing | Y N | Days Per Week: | Comments: |
| i. Amputation/Prosthesis Care | Y N | Days Per Week: | Comments: |
| j. Communication | Y N | Days Per Week: | Comments: |
| k. Toileting | Y N | Days Per Week: | Comments: |

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# NURSING FACILITY LEVEL OF CARE
# REQUEST FOR ADMISSION

Additional Safety/Health Information Pertinent to Admission (i.e., Wanderguard, bed/chair alarm, locked unit/building, full side rails, etc.)

PLEASE FAX **ALL PASRR** INFORMATION WITH **NEW ADMISSION** REQUESTS.

I certify that the MAP-726A information was reviewed by me. I attest that the foregoing information is true, accurate and complete.

_____/____/_____
RN/LPN Signature Date

_____/ /_____
Person Faxing Request Date

( ) ( )
Telephone Number Fax Number